PRINTED: 02/18/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155760 | A. BUILDING _____ B. WING _____ | R-C 02/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MAPLES AT WATERFORD CROSSING HEALTH CAMPUS | 1332 WATERFORD CIRCLE GOSHEN, IN 46526 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| {F 000} | INITIAL COMMENTS<br><br>This visit was for the Post Survey Revisit (PSR) to the investigation of Complaint Number IN00084191 completed on 1/7/11.<br><br>Complaint #IN00084191: Corrected<br><br>Unrelated findings cited.<br><br>Survey Dates: 2/14-15/11<br><br>Facility number: 011150<br>Provider number: 155760<br>Aim number: 200831020<br><br>Survey Team:<br>Ellen Ruppel, RN<br><br>Census bed type:<br>SNF: 24<br>SNF/NF: 41<br>Total: 65<br><br>Census payor type:<br>Medicare: 24<br>Medicaid: 18<br>Other: 23<br>Total: 65<br><br>Sample: 6<br><br>These deficiencies also reflect state finding in accordance with 410 IAC 16.2<br><br>Quality review completed 2-17-11<br>Cathy Emswiller RN | {F 000} | RECEIVED<br>FEB 28 2011<br>LONG TERM CARE DIVISION<br>INDIANA STATE DEPARTMENT OF HEALTH | |
| F 282 SS=G | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN | F 282 | | |

app 3/2/11 BM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carol D Emmons TITLE: Administrator (X6) DATE: 2/25/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 282 | Continued From page 1<br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews and record review, the facility failed to follow physician's orders for 1 of 6 residents whose records were reviewed for accuracy of medications. This deficit practice resulted in the resident receiving two types of incorrect medications (insulin and eye medication)and the omission of two additional medications (blood thinner and appetite stimulant.) The resident sustained a hypoglycemic reaction, resulting in a fall and required emergency room treatment. Resident B<br><br>Findings Include:<br><br>1. During the orientation tour, on 2/14/11 at 9:00 a.m., the Director of Nursing (DoN) identified Resident B as being a recent admission to the facility and having had a fall in the early morning hours of 2/14/11. The resident was observed to have abrasions on the forehead and both sides of his face. The right eye was beginning to turn dark in color.<br><br>The clinical record of Resident B was reviewed, on 2/14/11 at 10:50 a.m., and indicated the resident had been admitted to the facility on 2/7/11, from the Veteran's Administration Healthcare System (VA). His diagnoses included, but were not limited to: diabetes, hypertension, back pain, glaucoma and urinary tract infection. | F 282 | 1: The resident's insulin and accucheck orders were clarified with the attending phsyician during the time of survey. The resident's eye drops, Megace and Lovenox orders were clarified with the attending physician during the time of survey.<br>2: All admission charts since the original date of compliance, 2/6/11, were audited for accuracy of order transcription on admission and orders needing clarification were addressed and clarified with the attending physician during the time of survey.<br>3: All licensed nurses were in-serviced on order transcription and how to complete admission orders. All licensed nurses were in-serviced on what types of orders need clarification and how to clarify orders. All licensed nurses were in-serviced on the different types of insulin including onset, peak, duration. All licensed nurses were in-serviced on the guidelines for managing hypoglycemia and hyperglycemia. An insulin reference chart has been placed in each MAR for reference by the licensed nurses. | 2/28/11 |

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| F 282 | Continued From page 2<br>The admission orders from the VA included: "INSULIN, ASPART, HUMAN 100 UNIT/ML INJ INJECT 12 UNITS UNDER SKIN THREE TIMES DAILY BEFORE MEALS." This order had been transcribed as "Human 100u/ml 12 U subq (subcutaneous) tid (three times daily) (before) meals." The Aspart insulin is Novolog which has an onset in 15 minutes, with 1 to 2 hours peak and 3-5 hours duration. The Human is Novolin which is Regular insulin with an onset of 0.5 -1 hour, and a peak in 2.5-5 hours and duration of 8-12 hours. The Human was the wrong type of insulin. This information was obtained from a fact sheet provided by the corporate nurse and DoN, on 2/14/11 at 1:30 p.m..<br><br>The order also included "INSULIN, GLARGINE, HUMAN 100 UNIT/ML INJ (INJECT) 45 UNITS UNDER SKIN AT BEDTIME DO NOT MIX WITH OTHER INSULINS" This order had been transcribed as "Human R 100u/ml (100 units per milliliter) 45 u (units) subq (every) hs (hour of sleep)." The Glargine insulin is Lantus Insulin with an onset of 1.5 hours, constant peak and 24 hours duration. The Lantus is long acting insulin and the order had been transcribed for short acting insulin. This information was obtained from a fact sheet provided by the corporate nurse and DoN, on 2/14/11 at 1:30 p.m..<br><br>The admission orders included insulin coverage, "INSULIN, HUMAN REGULAR 100 UNT/ML INJ 180-200 4U (4 units of insulin), 201-250 6U, 251-300 8U, 301-350 12U, 351-400 15U, SC (sliding scale) QID (four times daily) AC (before meals) GREATER THAN 400 UNITS CALL MD (medical doctor)." This order had not been transcribed on the medication record. | F 282 | 4: Admission orders will be written and verified with the attending physician on admission. A second nurse will verify accuracy of orders and transcription to the MAR on admission. Neither one of these nurses will be the DHS. The DHS or designee will perform an audit of all admission charts for completeness and accuracy of transcription of admission orders within 24 hours and make a notation of review on the admission checklist. The DHS or designee will ensure that any orders needing clarification are clarified. The DCS will audit weekly the admission charts for completeness and accuracy of admission orders and will make a notation of review on the admission checklist. The unit managers will review all new orders in morning meeting and clarify any orders at that time with the attending physician. The unit managers will verify correct transcription at the time of review of the new order. The DHS or designee will perform a random audit weekly of new orders for correct transcription and accuracy of orders. The DHS will report monthly to the QA&A Committee on outcomes of the audits for the next 6 months, and thereafter as determined by the QAA | |

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| F 282 | Continued From page 3<br>Resident B had not received the correct insulin for any of the 7 days he had been in the facility and had received no coverage for blood sugars above 180. Twelve times the glucometer checks indicated the blood sugar was above the parameter for coverage.<br><br>Observation of the insulin in the medication cart, on 2/14/11 at 11:00 a.m., indicated only one vial of insulin for Resident B. It was Humulin R 100 units/ ml. and the label indicated, " use 12 units sub-q 3 times a day with meals and 45 units sub-q at bedtime." The nurse (LPN #4) giving medications on Resident B's hall was queried about his insulin, on 2/14/11 at 11:10 a.m., and she indicated it was the only one used for him.<br><br>Review of the clinical record for Resident B, on 2/14/11 at 10:50 a.m., indicated the night nurse had recorded in the nurse's notes at 12:10 a.m., "Res (resident) found lying on floor next to bed on l (left) side. Res not responding to verbal or physical stimuli. B/P (blood pressure) 130/76, P (pulse) 101, R (respirations) 18. res has abrasions to forehead, nose, and both (upper) cheek bones, bleeding minimally--Res BS (blood sugar) @ (at) 23. Glucagon injection given and 911 EMT (emergency medical technicians) called. Res remains unresponsive. BS @ 24. 0030 (12:30 a.m.) EMT'S arrive, more glucose given by EMTs. Res after 5 mins (minutes) able to answer simple questions, often with wrong response. attempted c (with) EMT, to put res back in bed. While attempting to set res upright, Res. verbalized large amt (amount) of pain in back. EMT's placed on gurney and removed res. from building to (local hospital)., family, Dr and unit manager notified. Will inform Dr of Res need for f/u (follow up) c (with) BS (blood sugar) and | F 282 | committee. The DHS is responsible for substantial compliance. | |

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| F 282 | Continued From page 4<br>insulin."<br><br>The hospital report, dated 2/14/11, indicated no fractures. Resident B was sent back to the facility, on 2//14/11 with orders to decrease is insulin to 8 units at meal times and 30 units at bedtime. Orders for Keflex (antibiotic) 500 mg four times daily for 10 days and Bacitracin to the wounds three times daily until they were healed were sent by the hospital on 2/14/11.<br><br>The physician was notified of the errors in insulin administration, on 2/14/11 and ordered the correction to Lantus 45 units at bedtime, Novolog 8 units at mealtime and coverage with Humulin R as had been originally ordered at the time of admission from the VA.<br><br>Resident B had received 22 doses of the wrong type of insulin and missed 12 coverage doses, during the period from his admission on 2/7 to 2/14/11.<br><br>2. The admission orders for Resident B also included an order for "drozolamide 2/timolol 0.5% (Cosopt) opth sol (ophthalmic solution) 1 drop ou (both eyes) bid (twice daily)." This order had been transcribed as "Timolol 0.5% (timoptic) instill 1 drop in both eyes BID." The resident had received the wrong eye drops for 7 days. Cosopt is a medication for glaucoma eye disease.<br><br>Observation of the eye drops in the medication cart, on 2/15/11 at 8:00 a.m., indicated the only eye drops for Resident B were Timoptic.<br><br>3. The admission orders for Resident B included an order for "ENOXAPARIN INJ 30 MG/ 0.3 ML SQ EVERY DAY." This order had not been | F 282 | | |

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| F 282 | Continued From page 5<br>transcribed and the resident had not received any of the doses of the injectable blood thinner.<br><br>4. The 2/7/11 admission orders for Resident B also included an order for "MEGESTROL TAB 40 MG PO (orally) BID." This order had not been transcribed and the resident had not received any doses of the appetite stimulator.<br><br>3.1-35(g)(2) | F 282 | | |
| F 333 SS=G | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews and record review, the facility failed to ensure 1 of 3 residents who received insulin, in a sample of 6, received the correct insulin dosages and coverages. The facility also failed to ensure medications were transcribed and administered as ordered to 1 of 6 residents whose records were reviewed for accuracy of medications. This deficit practice resulted in the resident receiving two types of incorrect medications (insulin and eye medication) and the omission of two additional medications (blood thinner and appetite stimulant.) The resident sustained a hypoglycemic reaction, resulting in a fall and required emergency room treatment. Resident B<br><br>Resident B<br><br>Findings Include: | F 333 | 1: The resident's insulin and accucheck orders were clarified with the attending physician during the time of survey. The resident's eye drops, megace and Lovenox orders were clarified with the attending physician during the time of survey.<br>2:All admission charts since the original date of compliance, 2/6/11, were audited for accuracy of order transcription on admission and orders needing clarification were addressed and clarified with the attending physician during the time of survey. All diabetics were reviewed for accuracy of their insulin and accucheck orders and parameters for calling the attending physician were obtained. | 2/28/11 |

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| F 333 | Continued From page 6<br>1. During the orientation tour, on 2/14/11 at 9:00 a.m., the Director of Nursing (DoN) identified Resident B as being a recent admission to the facility and having had a fall in the early morning hours of 2/14/11. The resident was observed to have abrasions on the forehead and both sides of his face. The right eye was beginning to turn dark in color.<br><br>The clinical record of Resident B was reviewed, on 2/14/11 at 10:50 a.m., and indicated the resident had been admitted to the facility on 2/7/11, from the Veteran's Administration Healthcare System (VA). His diagnoses included, but were not limited to: diabetes, hypertension, back pain, glaucoma and urinary tract infection.<br><br>The admission orders from the VA included: "INSULIN, ASPART, HUMAN 100 UNIT/ML INJ INJECT 12 UNITS UNDER SKIN THREE TIMES DAILY BEFORE MEALS." This order had been transcribed as "Human 100u/ml 12 U subq (subcutaneous) tid (three times daily) (before) meals." The Aspart insulin is Novolog which has an onset in 15 minutes, with 1 to 2 hours peak and 3-5 hours duration. The Human is Novolin which is Regular insulin with an onset of 0.5 -1 hour, and a peak in 2.5-5 hours and duration of 8-12 hours. The Human was the wrong type of insulin. This information was obtained from a fact sheet provided by the corporate nurse and DoN, on 2/14/11 at 1:30 p.m..<br><br>The order also included "INSULIN, GLARGINE, HUMAN 100 UNIT/ML INJ (INJECT) 45 UNITS UNDER SKIN AT BEDTIME DO NOT MIX WITH OTHER INSULINS" This order had been transcribed as "Human R 100u/ml (100 units per milliliter) 45 u (units) subq (every) hs (hour of | F 333 | 3: All licensed nurses were in-serviced on order transcription and how to complete admission orders. All licensed nurses were in-serviced on the different types of insulin including on sent, peak, duration. All licensed nurses were in-serviced on the guidelines for managing hypoglycemia and hyperglycemia. An insulin reference chart has been placed in each MAR for reference by the licensed nurses. All licensed nurses were in-serviced on completing and documenting on the diabetic flow sheet for all resident receiving accuchecks<br>4: Admission orders will be written and verified with the attending physician on admission. A second nurse will verify accuracy of orders and transcription to the MAR on admission. Neither one of these nurses will be the DHS. The DHS or designee will perform an audit of all admission charts for completeness and accuracy of transcription of admission orders within 24 hours and make a notation of review on the admission checklist. The DHS or designee will ensure that any orders needing clarification are clarified. The Director of Clinical Services will audit weekly the admission charts for completeness and accuracy of admission orders and will make a notation of review on the admission checklist. | |

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| F 333 | Continued From page 7<br>sleep)." The Glargine insulin is Lantus Insulin with an onset of 1.5 hours, constant peak and 24 hours duration. The Lantus is long acting insulin and the order had been transcribed for short acting insulin. This information was obtained from a fact sheet provided by the corporate nurse and DoN, on 2/14/11 at 1:30 p.m..<br><br>The admission orders included insulin coverage, "INSULIN, HUMAN REGULAR 100 UNT/ML INJ 180-200 4U (4 units of insulin), 201-250 6U, 251-300 8U, 301-350 12U, 351-400 15U, SC (sliding scale) QID (four times daily) AC (before meals) GREATER THAN 400 UNITS CALL MD (medical doctor)." This order had not been transcribed on the medication record.<br><br>Resident B had not received the correct insulin for any of the 7 days he had been in the facility and had received no coverage for blood sugars above 180. Twelve times the glucometer checks indicated the blood sugar was above the parameter for coverage.<br><br>Observation of the insulin in the medication cart, on 2/14/11 at 11:00 a.m., indicated only one vial of insulin for Resident B. It was Humulin R 100 units/ ml. and the label indicated, " use 12 units sub-q 3 times a day with meals and 45 units sub-q at bedtime." The nurse (LPN #4) giving medications on Resident B's hall was queried about his insulin, on 2/14/11 at 11:10 a.m., and she indicated it was the only one used for him.<br><br>Review of the clinical record for Resident B, on 2/14/11 at 10:50 a.m., indicated the night nurse had recorded in the nurse's notes at 12:10 a.m., "Res (resident) found lying on floor next to bed on l (left) side. Res not responding to verbal or | F 333 | The unit mangers will review all new orders in the morning meeting and clarify any orders at that time with the attending physician. The unit managers will verify correct transcription at the time of review of the new order. The DHS or designee will<br>perform a random audit weekly of new orders for correct transcription and accuracy of orders. The DHS or designee will<br>perform a random audit weekly of all residents with insulin coverage to verify accurate and complete documentation of the blood sugars and insulin coverage given in addition to appropriate and timely notification of the physician. The DHS will report monthly on outcomes of the audits for the next 6 months to the QA&A Committee, and thereafter as<br>determined by the QAA committee. The DHS is responsible for substantial compliance. | |

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| F 333 | Continued From page 8<br>physical stimuli. B/P (blood pressure) 130/76, P (pulse) 101, R (respirations) 18. res has abrasions to forehead, nose, and both (upper) cheek bones, bleeding minimally--Res BS (blood sugar) @ (at) 23. Glucagon injection given and 911 EMT (emergency medical technicians) called. Res remains unresponsive. BS @ 24. 0030 (12:30 a.m.) EMT'S arrive, more glucose given by EMTs. Res after 5 mins (minutes) able to answer simple questions, often with wrong response. attempted c (with) EMT, to put res back in bed. While attempting to set res upright, Res. verbalized large amt (amount) of pain in back. EMT's placed on gurney and removed res. from building to (local hospital)., family, Dr and unit manager notified. Will inform Dr of Res need for f/u (follow up) c (with) BS (blood sugar) and insulin."<br><br>The hospital report, dated 2/14/11, indicated no fractures. Resident B was sent back to the facility, on 2//14/11 with orders to decrease is insulin to 8 units at meal times and 30 units at bedtime. Orders for Keflex (antibiotic) 500 mg four times daily for 10 days and Bacitracin to the wounds three times daily until they were healed were sent by the hospital on 2/14/11.<br><br>The physician was notified of the errors in insulin administration, on 2/14/11 and ordered the correction to Lantus 45 units at bedtime, Novolog 8 units at mealtime and coverage with Humulin R as had been originally ordered at the time of admission from the VA.<br><br>Resident B had received 22 doses of the wrong type of insulin and missed 12 coverage doses, during the period from his admission on 2/7 to 2/14/11. | F 333 | | |

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| MAPLES AT WATERFORD CROSSING HEALTH CAMPUS | 1332 WATERFORD CIRCLE GOSHEN, IN 46526 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 333 | Continued From page 9<br><br>2. The admission orders for Resident B also included an order for "drozolamide 2/timolol 0.5% (Cosopt) opth sol (ophthalmic solution) 1 drop ou (both eyes) bid (twice daily)." This order had been transcribed as "Timolol 0.5% (timoptic) instill 1 drop in both eyes BID." The resident had received the wrong eye drops for 7 days. Cosopt is a medication for glaucoma eye disease.<br><br>Observation of the eye drops in the medication cart, on 2/15/11 at 8:00 a.m., indicated the only eye drops for Resident B were Timoptic.<br><br>3. The admission orders for Resident B included an order for "ENOXAPARIN INJ 30 MG/ 0.3 ML SQ EVERY DAY." This order had not been transcribed and the resident had not received any of the doses of the injectable blood thinner.<br><br>4. The 2/7/11 admission orders for Resident B also included an order for "MEGESTROL TAB 40 MG PO (orally) BID." This order had not been transcribed and the resident had not received any doses of the appetite stimulator.<br><br>3.1-25(b)(9) | F 333 | | |